



General Assembly

January Session, 2015

Raised Bill No. 860

LCO No. 3040



Referred to Committee on AGING

Introduced by:
(AGE)

AN ACT CONCERNING PRESUMPTIVE MEDICAID ELIGIBILITY FOR HOME CARE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 17b-342 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective July 1, 2015*):

3 (a) The Commissioner of Social Services shall administer the
4 Connecticut home-care program for the elderly state-wide in order to
5 prevent the institutionalization of elderly persons who (1) [who] are
6 recipients of medical assistance, (2) [who] are eligible for such
7 assistance, (3) [who] would be eligible for medical assistance if
8 residing in a nursing facility, or (4) [who] meet the criteria for the state-
9 funded portion of the program under subsection [(i)] (j) of this section.
10 For purposes of this section, a long-term care facility is a facility that
11 has been federally certified as a skilled nursing facility or intermediate
12 care facility. The commissioner shall make any revisions in the state
13 Medicaid plan required by Title XIX of the Social Security Act prior to
14 implementing the program. The program shall be structured so that
15 the net cost to the state for long-term facility care in combination with
16 the services under the program shall not exceed the net cost the state

17 would have incurred without the program. The commissioner shall
18 investigate the possibility of receiving federal funds for the program
19 and shall apply for any necessary federal waivers. A recipient of
20 services under the program, and the estate and legally liable relatives
21 of the recipient, shall be responsible for reimbursement to the state for
22 such services to the same extent required of a recipient of assistance
23 under the state supplement program, medical assistance program,
24 temporary family assistance program or supplemental nutrition
25 assistance program. Only a United States citizen or a noncitizen who
26 meets the citizenship requirements for eligibility under the Medicaid
27 program shall be eligible for home-care services under this section,
28 except a qualified alien, as defined in Section 431 of Public Law 104-
29 193, admitted into the United States on or after August 22, 1996, or
30 other lawfully residing immigrant alien determined eligible for
31 services under this section prior to July 1, 1997, shall remain eligible for
32 such services. Qualified aliens or other lawfully residing immigrant
33 aliens not determined eligible prior to July 1, 1997, shall be eligible for
34 services under this section subsequent to six months from establishing
35 residency. Notwithstanding the provisions of this subsection, any
36 qualified alien or other lawfully residing immigrant alien or alien who
37 formerly held the status of permanently residing under color of law
38 who is a victim of domestic violence or who has intellectual disability
39 shall be eligible for assistance pursuant to this section. Qualified aliens,
40 as defined in Section 431 of Public Law 104-193, or other lawfully
41 residing immigrant aliens or aliens who formerly held the status of
42 permanently residing under color of law shall be eligible for services
43 under this section provided other conditions of eligibility are met.

44 (b) The commissioner shall solicit bids through a competitive
45 process and shall contract with an access agency, approved by the
46 Office of Policy and Management and the Department of Social
47 Services as meeting the requirements for such agency as defined by
48 regulations adopted pursuant to subsection [(e)] (n) of this section, that
49 submits proposals [which] that meet or exceed the minimum bid

50 requirements. In addition to such contracts, the commissioner may use
51 department staff to provide screening, coordination, assessment and
52 monitoring functions for the program.

53 (c) The community-based services covered under the program shall
54 include, but not be limited to, [the following] services [to the extent
55 that they] that are not available under the state Medicaid plan, such as
56 occupational therapy, homemaker services, companion services, meals
57 on wheels, adult day care, transportation, mental health counseling,
58 care management, elderly foster care, minor home modifications and
59 assisted living services provided in state-funded congregate housing
60 and in other assisted living pilot or demonstration projects established
61 under state law. Personal care assistance services shall be covered
62 under the program to the extent that (1) such services are not available
63 under the Medicaid state plan and are more cost effective on an
64 individual client basis than existing services covered under such plan,
65 and (2) the provision of such services is approved by the federal
66 government. Recipients of state-funded services, pursuant to subsection
67 (j) of this section, and persons who are determined to be functionally
68 eligible for community-based services who have an application for
69 medical assistance pending, or are determined to be presumptively
70 eligible for Medicaid pursuant to subsection (e) of this section, shall
71 have the cost of home health and community-based services covered
72 by the program, provided they comply with all medical assistance
73 application requirements. Access agencies shall not use department
74 funds to purchase community-based services or home health services
75 from themselves or any related parties.

76 (d) Physicians, hospitals, long-term care facilities and other licensed
77 health care facilities may disclose, and, as a condition of eligibility for
78 the program, elderly persons, their guardians, and relatives shall
79 disclose, upon request from the Department of Social Services, such
80 financial, social and medical information as may be necessary to enable
81 the department or any agency administering the program on behalf of
82 the department to provide services under the program. Long-term care

83 facilities shall supply the Department of Social Services with the names
84 and addresses of all applicants for admission. Any information
85 provided pursuant to this subsection shall be confidential and shall not
86 be disclosed by the department or administering agency.

87 [(e) The commissioner shall adopt regulations, in accordance with
88 the provisions of chapter 54, to define "access agency", to implement
89 and administer the program, to establish uniform state-wide standards
90 for the program and a uniform assessment tool for use in the screening
91 process and to specify conditions of eligibility.]

92 (e) Not later than October 1, 2015, the Commissioner of Social
93 Services shall establish a system under which the state shall fund
94 services under the Connecticut home-care program for the elderly for a
95 period of up to ninety days for applicants who require a skilled level of
96 nursing care and who are determined to be presumptively eligible for
97 Medicaid coverage. The system shall include, but not be limited to: (1)
98 The development of a preliminary screening tool by the Department of
99 Social Services to be used by representatives of the access agency
100 selected pursuant to subsection (b) of this section to determine whether
101 an applicant is functionally able to live at home or in a community
102 setting and is likely to be financially eligible for Medicaid; (2)
103 authorization by the commissioner for such access agency
104 representatives to initiate home-care services not later than five days
105 after such functional eligibility determination for applicants deemed
106 likely to be eligible for Medicaid; (3) a presumptive financial Medicaid
107 eligibility determination for such applicants by the department not
108 later than four days after the functional eligibility determination; and
109 (4) a written agreement to be signed by such applicant attesting to the
110 accuracy of financial and other information such applicant provides
111 and acknowledging that (A) state-funded services shall be provided
112 not later than ninety days after the date on which the applicant applies
113 for Medicaid coverage, and (B) such applicant shall complete a
114 Medicaid application on the date such applicant is screened for
115 functional eligibility or not later than ten days after such screening.

116 The department shall make a final determination as to Medicaid
117 eligibility for presumptive eligibility applicants not later than forty-
118 five days after the date of receipt of a completed Medicaid application
119 from such applicant.

120 (f) To the extent permissible under federal law, the Commissioner of
121 Social Services shall retroactively apply a final determination of
122 Medicaid eligibility for presumptive Medicaid eligibility applicants for
123 a period not to exceed ninety days before such person's Medicaid
124 application.

125 ~~[(f)]~~ (g) The commissioner may require long-term care facilities to
126 inform applicants [for admission] of the Connecticut home-care
127 program for the elderly established under this section and to distribute
128 such forms as the commissioner prescribes for the program. Such
129 forms shall be supplied by and be returnable to the department.

130 ~~[(g)]~~ (h) The commissioner shall report annually, by June first, in
131 accordance with the provisions of section 11-4a, to the joint standing
132 committee of the General Assembly having cognizance of matters
133 relating to human services on the Connecticut home-care program for
134 the elderly in such detail, depth and scope as said committee requires
135 to evaluate the effect of the program on the state and program
136 participants. Such report shall include information on (1) the number
137 of persons diverted from placement in a long-term care facility as a
138 result of the program, (2) the number of persons screened [, (3)] for the
139 program, (3) the number of persons determined presumptively eligible
140 for Medicaid, (4) savings for the state based on how much institutional
141 care would have cost for persons determined to be presumptively
142 eligible for Medicaid who later were determined to be eligible for
143 Medicaid, (5) the number of persons determined presumptively
144 eligible for Medicaid who later were determined not to be eligible for
145 Medicaid and costs to the state to provide such persons with home
146 care services before the final Medicaid eligibility determination, (6) the
147 average cost per person in the program, [(4)] (7) the administration

148 costs, [(5)] (8) the estimated savings to provide home care versus
149 institutional care for all persons in the program, and [(6)] (9) a
150 comparison between costs under the different contracts.

151 [(h)] (i) An individual who is otherwise eligible for services
152 pursuant to this section shall, as a condition of participation in the
153 program, apply for medical assistance benefits [pursuant to section
154 17b-260] when requested to do so by the department and shall accept
155 such benefits if determined eligible.

156 [(i)] (j) (1) On and after July 1, 1992, the Commissioner of Social
157 Services shall, within available appropriations, administer a state-
158 funded portion of the Connecticut home-care program for the elderly
159 [persons] for persons (A) who are sixty-five years of age and older and
160 are not eligible for Medicaid; (B) who are inappropriately
161 institutionalized or at risk of inappropriate institutionalization; (C)
162 whose income is less than or equal to the amount allowed [under
163 subdivision (3) of subsection (a) of this section] for a person who
164 would be eligible for medical assistance if residing in a nursing facility;
165 and (D) whose assets, [if single, do not exceed the minimum
166 community spouse protected amount pursuant to Section 4022.05 of
167 the department's uniform policy manual or, if married, the couple's
168 assets do not exceed one hundred fifty per cent of said community
169 spouse protected amount and on and after April 1, 2007, whose assets,]
170 if single, do not exceed one hundred fifty per cent of the minimum
171 community spouse [protected amount] resource allowance pursuant to
172 [Section 4022.05] 42 USC 1396r-5(f)(2) as set forth in [of] the
173 department's uniform policy manual or, if married, the couple's assets
174 do not exceed two hundred per cent of said community spouse
175 protected amount.

176 (2) Except for persons residing in affordable housing under the
177 assisted living demonstration project established pursuant to section
178 17b-347e, as provided in subdivision (3) of this subsection, any person
179 whose income is at or below two hundred per cent of the federal

180 poverty level and who is ineligible for Medicaid shall contribute seven
181 per cent of the cost of his or her care. Any person whose income
182 exceeds two hundred per cent of the federal poverty level shall
183 contribute seven per cent of the cost of his or her care in addition to the
184 amount of applied income determined in accordance with the
185 methodology established by the Department of Social Services for
186 recipients of medical assistance. Any person who does not contribute
187 to the cost of care in accordance with this subdivision shall be
188 ineligible to receive services under this subsection. Notwithstanding
189 [any provision of the general statutes] sections 17b-60 and 17b-61, the
190 department shall not be required to provide an administrative hearing
191 to a person found ineligible for services under this subsection because
192 of a failure to contribute to the cost of care.

193 (3) Any person who resides in affordable housing under the assisted
194 living demonstration project established pursuant to section 17b-347e
195 and whose income is at or below two hundred per cent of the federal
196 poverty level, shall not be required to contribute to the cost of care.
197 Any person who resides in affordable housing under the assisted
198 living demonstration project established pursuant to section 17b-347e
199 and whose income exceeds two hundred per cent of the federal
200 poverty level, shall contribute to the applied income amount
201 determined in accordance with the methodology established by the
202 Department of Social Services for recipients of medical assistance. Any
203 person whose income exceeds two hundred per cent of the federal
204 poverty level and who does not contribute to the cost of care in
205 accordance with this subdivision shall be ineligible to receive services
206 under this subsection. Notwithstanding [any provision of the general
207 statutes] sections 17b-60 and 17b-61, the department shall not be
208 required to provide an administrative hearing to a person found
209 ineligible for services under this subsection because of a failure to
210 contribute to the cost of care.

211 (4) The annualized cost of services provided to an individual under
212 the state-funded portion of the program shall not exceed fifty per cent

213 of the weighted average cost of care in nursing homes in the state,
214 except an individual who received services costing in excess of such
215 amount under the Department of Social Services in the fiscal year
216 ending June 30, 1992, may continue to receive such services, provided
217 the annualized cost of such services does not exceed eighty per cent of
218 the weighted average cost of such nursing home care. The
219 commissioner may allow the cost of services provided to an individual
220 to exceed the maximum cost established pursuant to this subdivision
221 in a case of extreme hardship, as determined by the commissioner,
222 provided in no case shall such cost exceed that of the weighted cost of
223 such nursing home care.

224 [(j)] (k) The Commissioner of Social Services may implement revised
225 criteria for the operation of the program while in the process of
226 adopting such criteria in regulation form, provided the commissioner
227 prints notice of intention to adopt the regulations [in the Connecticut
228 Law Journal] on the Internet web site of the department and the
229 eRegulations System within twenty days of implementing the policy.
230 Such criteria shall be valid until the time final regulations are effective.

231 [(k)] (l) The commissioner shall notify any access agency or area
232 agency on aging that administers the program when the department
233 sends a redetermination of eligibility form to an individual who is a
234 client of such agency.

235 [(l)] (m) In determining eligibility for the program described in this
236 section, the commissioner shall not consider as income Aid and
237 Attendance pension benefits granted to a veteran, as defined in section
238 27-103, or the surviving spouse of such veteran.

239 (n) The commissioner shall adopt regulations, in accordance with
240 the provisions of chapter 54, to (1) define "access agency", (2)
241 implement and administer the Connecticut home-care program for the
242 elderly, (3) implement and administer the presumptive Medicaid
243 eligibility system, (4) establish uniform state-wide standards for the

244 program and a uniform assessment tool for use in the screening
245 process, and (5) specify conditions of eligibility.

246 Sec. 2. Subsection (a) of section 17b-253 of the general statutes is
247 repealed and the following is substituted in lieu thereof (*Effective July*
248 *1, 2015*):

249 (a) The Department of Social Services shall seek appropriate
250 amendments to its Medicaid regulations and state plan to allow
251 protection of resources and income pursuant to section 17b-252. Such
252 protection shall be provided, to the extent approved by the federal
253 Centers for Medicare and Medicaid Services, for any purchaser of a
254 precertified long-term care policy and shall last for the life of the
255 purchaser. Such protection shall be provided under the Medicaid
256 program or its successor program. Any purchaser of a precertified
257 long-term care policy shall be guaranteed coverage under the
258 Medicaid program or its successor program, to the extent the
259 individual meets all applicable eligibility requirements for the
260 Medicaid program or its successor program. Until such time as
261 eligibility requirements are prescribed for Medicaid's successor
262 program, for the purposes of this subsection, the applicable eligibility
263 requirements shall be the Medicaid program's requirements as of the
264 date its successor program was enacted. The Department of Social
265 Services shall count insurance benefit payments toward resource
266 exclusion to the extent such payments (1) are for services paid for by a
267 precertified long-term care policy; (2) are for the lower of the actual
268 charge and the amount paid by the insurance company; (3) are for
269 nursing home care, or formal services delivered to insureds in the
270 community as part of a care plan approved by an access agency
271 approved by the Office of Policy and Management and the
272 Department of Social Services as meeting the requirements for such
273 agency as defined in regulations adopted pursuant to subsection [(e)]
274 (n) of section 17b-342, as amended by this act; and (4) are for services
275 provided after the individual meets the coverage requirements for
276 long-term care benefits established by the Department of Social

277 Services for this program. The Commissioner of Social Services shall
278 adopt regulations, in accordance with chapter 54, to implement the
279 provisions of this subsection and sections 17b-252, 17b-254 and 38a-
280 475, as amended by this act, relating to determining eligibility of
281 applicants for Medicaid, or its successor program, and the coverage
282 requirements for long-term care benefits.

283 Sec. 3. Subdivision (1) of subsection (g) of section 17b-354 of the
284 general statutes is repealed and the following is substituted in lieu
285 thereof (*Effective July 1, 2015*):

286 (g) (1) A continuing care facility which guarantees life care for its
287 residents, as defined in subsection (b) of this section, (A) shall arrange
288 for a medical assessment to be conducted by an independent physician
289 or an access agency approved by the Office of Policy and Management
290 and the Department of Social Services as meeting the requirements for
291 such agency as defined by regulations adopted pursuant to subsection
292 [(e)] (n) of section 17b-342, as amended by this act, prior to the
293 admission of any resident to the nursing facility and shall document
294 such assessment in the resident's medical file, and (B) may transfer or
295 discharge a resident who has intentionally transferred assets in a sum
296 which will render the resident unable to pay the cost of nursing facility
297 care in accordance with the contract between the resident and the
298 facility.

299 Sec. 4. Subsection (a) of section 17b-617 of the general statutes is
300 repealed and the following is substituted in lieu thereof (*Effective July*
301 *1, 2015*):

302 (a) The Commissioner of Social Services shall, within available
303 appropriations, establish and operate a state-funded pilot program to
304 allow not more than one hundred persons with disabilities (1) who are
305 age eighteen to sixty-four, inclusive, (2) who are inappropriately
306 institutionalized or at risk of inappropriate institutionalization, and (3)
307 whose assets do not exceed the asset limits of the state-funded home

308 care program for the elderly, established pursuant to subsection [(i)] (j)
309 of section 17b-342, as amended by this act, to be eligible to receive the
310 same services that are provided under the state-funded home care
311 program for the elderly. At the discretion of the Commissioner of
312 Social Services, such persons may also be eligible to receive services
313 that are necessary to meet needs attributable to disabilities in order to
314 allow such persons to avoid institutionalization.

315 Sec. 5. Section 38a-475 of the general statutes is repealed and the
316 following is substituted in lieu thereof (*Effective July 1, 2015*):

317 The Insurance Department shall only precertify long-term care
318 insurance policies which (1) alert the purchaser to the availability of
319 consumer information and public education provided by the
320 Department on Aging pursuant to section 17b-251; (2) offer the option
321 of home and community-based services in addition to nursing home
322 care; (3) in all home care plans, include case management services
323 delivered by an access agency approved by the Office of Policy and
324 Management and the Department of Social Services as meeting the
325 requirements for such agency as defined in regulations adopted
326 pursuant to subsection [(e)] (n) of section 17b-342, as amended by this
327 act, which services shall include, but need not be limited to, the
328 development of a comprehensive individualized assessment and care
329 plan and, as needed, the coordination of appropriate services and the
330 monitoring of the delivery of such services; (4) provide inflation
331 protection; (5) provide for the keeping of records and an explanation of
332 benefit reports on insurance payments which count toward Medicaid
333 resource exclusion; and (6) provide the management information and
334 reports necessary to document the extent of Medicaid resource
335 protection offered and to evaluate the Connecticut Partnership for
336 Long-Term Care. No policy shall be precertified if it requires prior
337 hospitalization or a prior stay in a nursing home as a condition of
338 providing benefits. The commissioner may adopt regulations, in
339 accordance with chapter 54, to carry out the precertification provisions
340 of this section.

This act shall take effect as follows and shall amend the following sections:

Section 1	<i>July 1, 2015</i>	17b-342
Sec. 2	<i>July 1, 2015</i>	17b-253(a)
Sec. 3	<i>July 1, 2015</i>	17b-354(g)(1)
Sec. 4	<i>July 1, 2015</i>	17b-617(a)
Sec. 5	<i>July 1, 2015</i>	38a-475

Statement of Purpose:

To allow more elderly persons to receive more cost-effective care in a home setting rather than an institution by establishing a system of presumptive Medicaid eligibility.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]